Department of Medical Assistance Services

Strategic Planning

Fiscal Years 2007 & 2008

Part B
Service Area Plans

DMAS Agency Strategic Plan
Part B - Service Plans

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DMAS Agency Strategic Plan
Part B - Service Plans

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Service Area Plan

Department Of Medical Assistance Services

Reimbursements for Medical Services Related to Involuntary Mental Commitments (32107)

Service Area Background Information

Service Area Description

An Involuntary Mental Commitment, also known as a Temporary Detention Order (TDO), is the detainment of an individual who i) has been determined to be mentally ill and in need of hospitalization, ii) presents an imminent danger to self or others as result of the mental illness or is so seriously mentally ill as to be substantially unable to care for self, and iii) is incapable of volunteering or unwilling to volunteer for treatment. A magistrate issues the TDO. The duration of the order shall not exceed 48 hours prior to a commitment hearing. If the 48-hour period terminates on a Saturday, Sunday or legal holiday, such person may be detained until the next business day.

DMAS determines the allowable eligibility period for the client who is under an involuntary mental commitment and enrolls the client in the involuntary mental commitment program. DMAS ensures that all other available payment resources have been exhausted prior to payment by this program, which is funded only through state funds. Once this is completed, DMAS processes and adjudicates claims for the allowable services provided to clients under an involuntary mental commitment.

Service Area Alignment to Mission

This service area is in line with DMAS' mission to provide access to a comprehensive system of high quality and cost effective health care services to qualifying Virginians. By ensuring that appropriate services are provided to eligible persons, DMAS provides access to needed care for this population of clients

Service Area Statutory Authority

Code of Virginia §37.1 – 67.4: This section provides the process for an individual who is in danger of harming himself/herself or others to have a mental health evaluation to determine the correct plan of action and treatment. Should this evaluation result in the issuance of an involuntary detention order, the timeframe for the detainment is outlined and the payer of the services provided during the detention is identified.

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients	8,392	0

Anticipated Changes In Service Area Customer Base

The number of clients placed under an involuntary mental commitment has remained relatively constant over the past five years and no significant change in this population is anticipated at this time.

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Operations (Enrollment & Member Services) – Determination of the involuntary mental commitment eligibility and enrollment for providers and clients
- Operations (Provider Enrollment, Services and Reimbursement) – Determination of the per diem rate of reimbursement for all services provided
- Operations (Health Care Services) – Coverage for involuntary mental commitment services

Factors Impacting Service Area Products and Services

Provider knowledge of the involuntary commitment process and the timely filing of claims for their services impacts whether these services are used.

In addition, DMAS has received ongoing concerns regarding the lack of providers willing to accept and treat TDO clients within their facilities. DMAS' responsibility for this program does not encompass the process of placing TDOs within facilities; however, the lack of access for these services does impact the amount of expenditures incurred for this program.

Anticipated Changes To Service Area Products and Services

No changes are anticipated, unless there is legislative action that would increase or decrease the services.

Service Area Financial Summary

The Involuntary Mental Commitment program is funded 100% with state General Fund.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$11,180,391	$0	$11,180,391	$0
Changes To Base	($1,000,000)	$0	($1,000,000)	$0
SERVICE AREA TOTAL	**$10,180,391**	**$0**	**$10,180,391**	**$0**

Service Area Objectives, Measures, and Strategies

Objective 32107.01

Ensure that providers that are treating TDO clients continue to be compensated for the allowable services they provide and ensure that these services are within the timeframe of the commitment order.

Provide reimbursement for the services provided to the client who is detained under the involuntary mental commitment.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Council on Virginia's Future Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 32107.01.01**

  Percentage of accurate reimbursement payments processed within 30 calendar days of receipt at DMAS

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: FY 2006 - 92%

  Measure Target: FY 2007 - 90%

  Measure Source and Calculation:

  VaMMIS reports and a manual staff log will be used to capture the date a clean claim was received at DMAS, Julian date of processing by First Health, date adjudicated for payment, and actual remittance advice date.

Objective 32107.01 Has the Following Strategies:

- Revise and update TDO billing instructions.
- Provide training for providers on the TDO process and responsibility.
- Revise the inpatient activity and outpatient activity, professional and locality court reports to include year-to-date information as well as the recent month data that is currently shown.

Service Area Plan

Department Of Medical Assistance Services

Reimbursements for Medical Services Provided Under the Family Access to Medical Insurance Security Plan (44602)

Service Area Background Information

Service Area Description

The Family Access to Medical Insurance Security (FAMIS) program is part of Virginia's Title XXI program for uninsured children and pregnant women living below 200% and 166% of the federal poverty level (FPL) respectively. The FAMIS program provides access to comprehensive health care services for qualifying children through a benefit plan modeled on the state-employee health plan in areas where a contracted managed care organization is available; and through a Medicaid look-alike benefit plan in fee-for-service areas. FAMIS requires family cost sharing through co-payments for services and provides a premium assistance option for private/employer-sponsored insurance.

Service Area Alignment to Mission

FAMIS carries out the mission of DMAS by providing access to a comprehensive system of high quality and cost effective health care services to uninsured children whose families earn too much to qualify for Medicaid but too little to afford private health insurance.

Service Area Statutory Authority

Statutory Authority
CFR: 42 part 457
§32.1-351 Code of Virginia

Service Area Customer Base

Customer(s)	Served	Potential
Uninsured children under 19 with family income >133% FPL (federal poverty level) and < 200% FPL*	71,589	0
Uninsured pregnant women with income > 133% FPL and < 166% FPL**	631	700

Anticipated Changes In Service Area Customer Base

The customer base of children eligible for the FAMIS program is likely to remain approximately the same for the next several years. Factors that could affect the number of customers would include a downturn in the Virginia economy, private insurance market forces that result in an increase in rates of uninsurance, a significant increase in the under 19 population, or policy changes affecting program eligibility.

The customer base for the new FAMIS MOMS program for pregnant women is likely to grow in the next few years as the program matures. Similar to FAMIS, economic and population demographics will also impact the customer base for FAMIS MOMS.

Footnotes to Customer Base Listing Tab:
* Number of children served in FAMIS at any time in FY 2006. It is currently estimated that approximately 16,000 children could qualify for Medicaid (FAMIS Plus) or FAMIS but are not enrolled. It is unknown how many of these children would qualify solely for FAMIS.

**The number of pregnant women served in FAMIS MOMS at any time from August 1, 2005 through July 1, 2006.

Service Area Plan

Department Of Medical Assistance Services

Reimbursements for Medical Services Provided Under the Family Access to Medical Insurance Security Plan (44602)

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Federal agencies

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- FAMIS & FAMIS MOMS
  Coverage for comprehensive health care services through managed care or fee-for-service
  Marketing and outreach to promote enrollment
  Application processing and enrollment
  Claims payment

Factors Impacting Service Area Products and Services

Federal and state appropriations and regulations impact the nature and scope of the services than can be provided through FAMIS. Unlike Medicaid, FAMIS is not an entitlement program

Anticipated Changes To Service Area Products and Services

Congress must reauthorize Title XXI no later than September 30, 2007. It is likely the federal funding formula that determines Virginia's annual allotment will be revised.

Service Area Financial Summary

Non General Funds in FY2007 and FY2008 is comprised of Federal Funds and the Family Access to Medical Insurance Plan Trust Fund.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$17,288,065	$68,361,011	$17,288,065	$68,361,011
Changes To Base	$57,275	$4,343,163	$4,484,813	$12,565,732
SERVICE AREA TOTAL	**$17,345,340**	**$72,704,174**	**$21,772,878**	**$80,926,743**

Service Area Objectives, Measures, and Strategies

Objective 44602.01

Enroll all eligible children in the FAMIS program

While enrollment of eligible children in the FAMIS program has increased dramatically, there are still uninsured children who could be covered and additional children who become uninsured every day. It is in the best interest of the children, their families and the Commonwealth to provide comprehensive health care coverage through the FAMIS program to this vulnerable population.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Council on Virginia's Future Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 44602.01.01**

  Number of eligible children enrolled in FAMIS or FAMIS Plus

  Measure Type: Output **Measure Frequency:** Quarterly

  Measure Baseline: FY 2005 - 416,548

  Measure Target: FY 2006 and beyond - 430,878

  Measure Source and Calculation:
  Data Source: Data from VAMMIS on the number of children enrolled in FAMIS on the first day of each month, following all cancellations that occur on the last day of each month, will be reported. This number will be combined with enrollment data for FAMIS Plus (Medicaid) and compared to the number of children estimated to be eligible for publicly supported health insurance in Virginia for a percentage of overall enrollments
  Calculation: Estimates of eligible children are calculated by a formula based on Census data, poverty rates by locality and results of the 2000 Health Access Survey conducted by the Virginia Health Care Foundation. This formula is recalibrated periodically as current data become available (the last updates were made in January 2002 and January 2004).

Objective 44602.01 Has the Following Strategies:

- Develop and implement a general marketing campaign specifically designed to retain current children and reach families with FAMIS eligible children.
- Develop outreach activities and materials to reach traditionally "hard-to-reach" populations.
- Increase the use of technology to improve customer service for interested families and to facilitate application processing and enrollment.

Objective 44602.02

We will work to improve the oral health and increase the utilization of appropriate preventative care by FAMIS enrolled children (KEY)

Over 71,000 children have been served through the FAMIS program in FY 2005. This objective will focus DMAS' efforts to improve health outcomes for children and reduce long-term health care costs by improving the timely and appropriate utilization of preventive health care services.

This Objective Supports the Following Agency Goals:

- Promote better health outcomes through prevention-based strategies and improved quality of care.

  (Council on Virginia's Future Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 44602.02.01**

  Percentage of two year olds in FAMIS fully immunized (KEY OBJECTIVE)

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: CY 2004 = 89.6%

  Measure Target: FY 2008 = 92%

  Measure Source and Calculation:

  DMAS contracts with an external quality review organization to study the rate of appropriate immunizations for children covered by FAMIS and FAMIS PLUS. An annual report determines the number of children receiving the recommended immunizations by age group is divided by the number of children covered by the programs. HEDIS data from contracted managed care organizations and claims data are analyzed.

- **Measure 44602.02.02**

  Well-child visit rate (KEY OBJECTIVE)

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: FY 2004 - 51% of 15 month old children (and 62.5% of 3 to 6 year old children)

  Measure Target: CY 2008 - 70% for 15 month (and 3 to 6 year old children)

  Measure Source and Calculation:

  DMAS contracts with an External Quality Review Organization (EQRO) to study and produce an annual report of the utilization of appropriate well child visits by the FAMIS population. Both administrative claims data from VAMMIS and medical record data are reviewed. The rate of 15-month-old children receiving the recommended number of well-child visits is determined by comparing the number of children in this age group who received six or more well-child visits since birth to the total number of 15-month-old children enrolled. The rate of 3 to 6 year old children receiving recommended well-child visits is determined by comparing the number of children in this age group receiving one or more well-child visits during the study period to the total number of 3 to 6 year old children

- **Measure 44602.02.03**

  Percentage of FAMIS enrolled children who utilize dental services (KEY OBJECTIVE)

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: FY 2005 = 30.44%

  Measure Target: FY 2008 = 40%

  Measure Source and Calculation:

  DMAS claims data are utilized to determine the number of children covered by FAMIS or FAMIS PLUS between the age of three and twenty-one receiving routine dental care visits. This number is divided by the number of children in this age group enrolled in the program. Due to the claim process, final results lag the closing period by about six months.

Objective 44602.02 Has the Following Strategies:

- Continue to promote appropriate childhood immunizations for the FAMIS population.
- Promote utilization of well child check-ups covered by the FAMIS plan and remind providers of the importance of regular checkups, immunizations, and the coordination of information among providers.
- Promote utilization of preventive pediatric dental visits by the FAMIS population.

Service Area Background Information

Service Area Description

The service area reimburses facilities owned and operated by the Department of Mental Health and Mental Retardation and Substance Abuse Services (DMHMRSAS) for medically necessary services provided to Medicaid eligible recipients residing in these facilities.

The DMHMRSAS operates 15 state mental health or mental retardation facilities that provide highly structured intensive inpatient treatment and habilitation services. The state mental health facilities provide a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. The mental retardation training centers provide residential care and training in areas such as language, self-care, independent living, socialization, academic skills, and motor development. The Hiram Davis Medical Center provides medical care to state facility patients and residents.

DMAS works in partnership with the DMHMRSAS to ensure that services are medically necessary, provided in the most appropriate setting and that the reimbursement rates are sufficient to help maintain the financial viability of these state owned facilities.

Service Area Alignment to Mission

By providing coverage for the services provided through the Commonwealth's public MHMR facilities we are ensuring access to needed medical care for a vulnerable population.

Service Area Statutory Authority

Federal Legislation: Title XIX of the Social Security Act
CFR: 42 part 440
Code of Virginia: Chapter 32.1, Chapter 10

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients: Low-income, Aged, and Disabled Virginians with Mental Health/Mental Retardation Diagnoses	3,218	0

Anticipated Changes In Service Area Customer Base

The average daily census at Virginia's state mental health facilities and state mental retardation training centers has declined steadily over the past 30 years due to various facility discharge and diversion projects and the increased use of atypical antipsychotic medications. This trend is evident in the Medicaid-funded utilization, which has declined 61 percent at state mental health facilities and 16 percent at state mental retardation training centers over the past ten years. In fiscal year 2005, the Virginia Medicaid program covered treatment services for 966 residents of state mental health facilities and 1,596 residents of state mental retardation training centers*. This represents a four percent decline over the 2,663 individuals served in fiscal year 2004

* The Virginia Medicaid program covers services provided by both state-owned and private community mental health and mental retardation facilities. In FY 2005 a total of 1,401 individuals received fee-for-service inpatient mental health services and 1,914 individuals received fee-for-service inpatient mental retardation services. The numbers above refer only to those recipients served in state-owned facilities. The recipients served in private community facilities are included in other Service Area Plans.

Footnote to Service Area Customer Base Listing tab:
During the 2006-2008 biennium it is estimated there will be between 850,000 to 1,000,000 individuals enrolled in the Medicaid Program at some point during each fiscal year.

Service Area Partners

Advocacy groups

Service Area Partners

Federal agencies

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Operations (Health Care Services) - Coverage of Mental Health and Mental Retardation Health Care Services
- Operations (Financial Services) - Rate Setting/Cost Analysis
- Operations (Provider Enrollment, Services and Reimbursement) - Claims Payments; Prior Authorization

Factors Impacting Service Area Products and Services

Federal regulations limit the types of individuals who are eligible to receive Medicaid coverage in Institutions for Mental Disease (IMD). The CFR prohibits covering individuals between age 22 through age 64 while residing in an IMD. This does not apply to individuals diagnosed with Mental Retardation.

Total reimbursement to the facilities is limited by State appropriations.

Anticipated Changes To Service Area Products and Services

It is anticipated that services will decrease in accord with the trend of a declining population.

Service Area Financial Summary

Funding for the services is covered through the Medicaid program.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$107,991,696	$114,628,651	$107,991,696	$114,628,651
Changes To Base	($2,785,331)	($9,422,286)	($6,427,206)	($13,064,161)
SERVICE AREA TOTAL	**$105,206,365**	**$105,206,365**	**$101,564,490**	**$101,564,490**

Service Area Objectives, Measures, and Strategies

Objective 45607.01

To ensure appropriate and timely Medicaid funding of services provided to Medicaid eligible individuals in the DMHMRSAS facilities.

It is DMAS' responsibility to provide Medicaid payments to DMHMRSAS facilities, expending the state funds that are provided for this purpose and ensuring maximum feasible federal funding to the facilities.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Council on Virginia's Future Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families)

This Objective Has The Following Measure(s):

- **Measure 45607.01.01**

  Percentage of maximum feasible federal funds that are provided in reimbursement to the facilities.

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: 99.9% in FY 2005

  Measure Target: 99% or greater in FY 2007

  Measure Source and Calculation:
  Source: DMAS generated expenditure report from CARS (Budget balance file) by program 45607 for fund 1000. In addition, the budgeted amounts for this is obtained from the Appropriation Act. Calculation: Federal expenditures are divided by the federal budget to determine a percentage of funds used.

- **Measure 45607.01.02**

  Percentage of state funds made available to DMAS for these facilities that are provided in reimbursemen

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: 99.9% in FY 2005

  Measure Target: 99% or greater in FY 2007

  Measure Source and Calculation:
  Source: DMAS generated expenditure report from CARS (Budget balance file) by program 45607 for fund 0100. In addition, the budgeted amounts for this is obtained from the Appropriation Act. Calculation: State expenditures are divided by the state only budget to determine a percentage of funds used.

Objective 45607.01 Has the Following Strategies:

- Monitor payments to the facilities throughout the year to ensure the state appropriated funds are all paid.
- Perform an upper payment limit calculation and carry out a "certification" to draw down the maximum available federal funds.

Service Area Background Information

Service Area Description

This service area reimburses providers, both public and private, for the treatment of mental illness, including long-term serious mental illness and short-term acute problems and for mental retardation case management services. Other mental retardation based services are provided in the long term care service area. Medicaid covers outpatient services, inpatient services under certain circumstances, and community-based mental health rehabilitative services to individuals who meet specified criteria for each service.

DMAS, in partnership with the DMHMRSAS, the Community Services Boards and community providers and advocates, continues to work to ensure access to needed MHMR services in the most appropriate setting.

Service Area Alignment to Mission

By providing coverage for these mental health and mental retardation case management services we are ensuring needed medical care for a vulnerable population

Service Area Statutory Authority

Federal Legislation: Title XIX of the Social Security Act
CFR: 42, Part 440
Code of Virginia: Chapter 32.1, Chapter 10

Service Area Customer Base

Customer(s)	Served	Potential
Clients / Beneficiaries: Low-income. Aged. and Disabled Virginians with a MH/MR diagnosis	51.613	0

Anticipated Changes In Service Area Customer Base

In fiscal year 2005, the Virginia Medicaid program covered fee-for-service inpatient treatment services for 435 residents in private mental health facilities and fee-for-service outpatient mental health services for 51,178 individuals. This represents a fourteen percent growth over the number of individuals served in fiscal year 2004. This growth is due to several factors including overall growth in enrollment in the Virginia Medicaid program and a trend towards community-based, rather than institutional treatment settings. These factors are likely to lead to continued growth in the number of individuals receiving Medicaid-covered mental health services.

In addition, as the population ages, the Medicaid program is likely to see an increasing number of individuals with mental illness who will require community-based services to enable them to reside in a nursing home or assisted living facility.

Footnotes for Service Area Customer Base Listing tab:
*During the 2006-2008 biennium it is estimated there will be between 850,000 to 1,000,000 individuals enrolled in the Medicaid program at some point during each fiscal year. All recipients are eligible for these services if they are medically necessary.

The Virginia Medicaid program covers services provided by both state-owned and private community mental health and mental retardation facilities. In FY 2005 a total of 1,401 individuals received fee-for-service inpatient mental health services and 1,914 individuals received fee-for-service inpatient mental retardation services. The numbers above refer only to those recipients served in state-owned facilities. The recipients served in private community facilities are included in other Service Area Plans. These figures do not include the number of individuals who receive mental health or mental retardation services provided through a Medicaid capitated managed care plan.

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Federal agencies

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials
Federal agencies
State and local entities
Private business firms
Health care professionals, organizations, and facilities
State government officials

Service Area Products and Services

- Operations (Health Care Services) - Coverage of Mental Health Care Services
- Operations (Policy Analysis and Information Dissemination) - Establish policy and standards and disseminate information
- Operations (Financial Services) - Rate Setting and Financial Analysis
- Operations (Provider Enrollment, Services, And Reimbursement) - Claims processing and payment

Factors Impacting Service Area Products and Services

Federal regulations, Virginia's State Plan and the Code of Virginia all address mental health services covered by Medicaid.

In recent years there has been a significant increase in the number of mental health providers enrolled to participate in the Medicaid program. This has increased access to the services and increased utilization.

Anticipated Changes To Service Area Products and Services

Current trends toward new model of community-based care increase utilization of these services. In addition, current efforts are aimed at increasing flexibility to improve access.

Service Area Plan

Department Of Medical Assistance Services

Reimbursements for Mental Health and Mental Retardation Services (45608)

Service Area Financial Summary

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$246,641,311	$246,641,311	$246,641,311	$246,641,311
Changes To Base	($92,157,698)	($92,157,697)	($81,618,077)	($81,618,076)
SERVICE AREA TOTAL	**$154,483,613**	**$154,483,614**	**$165,023,234**	**$165,023,235**

Service Area Objectives, Measures, and Strategies

Objective 45608.01

Increase access to outpatient and community-based mental health services

Outpatient and community-based mental health services have proven to be a cost-effective alternative to inpatient placement and improve the quality of life for individuals in need of mental health treatment

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Council on Virginia's Future Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families)

This Objective Has The Following Measure(s):

- **Measure 45608.01.01**

  Outpatient/inpatient expense ratio

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: FY 2005 59 8%

  Measure Target: FY 2007 68%

  Measure Source and Calculation:
  Source: DMAS generated expenditure CARS report by applicable object codes for Institutional MH services (for State and private MH facilities and Psych facilities) and Community MH facilities. Calculation: Community MH Services costs are divided by all MH facility costs to determine a expense ratio.

Objective 45608.01 Has the Following Strategies:

- Continue to work with DMHMRSAS, the Community Service Boards, and community advocates and providers to identify barriers to access and implement changes to the extent allowed by federal and state regulations.

Service Area Plan

Department Of Medical Assistance Services

Reimbursements for Professional and Institutional Medical Services (45609)

Service Area Background Information

Service Area Description

This service area represents the largest single component of the Department's programs and activities, the Title XIX Medicaid program. The primary functions that the department performs in this area are: i) working with local departments of social services to enroll persons into the appropriate categories of eligibility; ii) providing support services to enrollees; iii) developing and maintaining provider networks and ensuring access to needed health services; iv) reimbursing providers for necessary and appropriate health care services; v) ensuring the program operates efficiently; and vi) developing new program features to improve the quality of care and control costs.

Service Area Alignment to Mission

By performing the functions within this service area, we are able to provide access to a comprehensive system of high quality and cost effective health care services to our customers.

Service Area Statutory Authority

Title XIX of the United States Code and Chapter 10 of Title 32 1 of the Code of Virginia

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients*	832,905	0
Internal Customers	0	0

Anticipated Changes In Service Area Customer Base

Approximately 87% of the department's customer base is served through the Medicaid program. Average monthly enrollment in this program grew 6% in fiscal year 2003 and 9% each year in fiscal years 2004 and 2005. The department's current forecast projects 6% growth in fiscal year 2006 and 3% growth in fiscal year 2007, based solely on historical trends.

In addition to average annual growth, the number of Virginians age 65 and older is projected to increase dramatically over the next ten years – over five times faster than the state's total population growth. This growth in turn will increase the number of individuals receiving Medicare premium assistance and long-term care services through Virginia's Medicaid program.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), established the Medicare Prescription Drug Program, also known as Medicare Part D, which provides prescription drug coverage to Medicare beneficiaries Virginians applying for Medicare Part D may find that they also qualify for Medicaid, which will increase the number of individuals served.

The increased ability of medical technology to prolong life will increase the department's customer base. Statistics show that the life expectancy at age 65 has increased 12% for males and 3% for females since 1980.

Outreach efforts to enroll additional children in FAMIS or Medicaid also will increase the customer base.

Economic conditions also affect the numbers of individuals eligible for medical assistance services. According to the Virginia Employment Commission, the final numbers for 2004 showed strong economic growth for both the U.S. and Virginia. Continued economic growth can be expected to produce a countervailing trend that may suppress the number of low-income Virginians and in turn the numbers of individuals needing medical assistance services.

Footnote for Service Area Customer Base Listings:
* Served represents enrolled individuals in Medicaid in FY 2005. During the 2006-2008 biennium it is estimated there will be between 850,000 to 1,000,000 individuals enrolled in the Medicaid program at some point during each fiscal year.

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Federal agencies

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Operations (Enrollment and Member Services)
- Operations (Provider Enrollment, Services, and Reimbursement) – Special provider Reimbursement Projects (E.G., Revenue Maximization, Teaching Hospital DSH)
- Operations (Program integrity) – Quality Assurance
- Operations (Healthcare Services) – Operational support; New Program Development (e.g., ED 2, DSM, Dental)

Factors Impacting Service Area Products and Services

The following factors will impact the services provided within this service area:

- The Governor's emphasis on enrolling additional children in Medicaid;
- Implementation of Medicare Part D
- Aging population
- Changes in economic conditions
- Health care cost inflation (technology)
- Federal policy changes and Medicaid reform initiatives
- Impact of low reimbursement on provider participation
- Managed care penetration by geographic area and population type
- Legislative initiatives/priorities
- Budgetary/resource restraints
- Growing emphasis on cost containment and program integrity

Anticipated Changes To Service Area Products and Services

- The Department will be required to develop and implement certain activities following the implementation of the Medicare Part D benefit.
- Application of managed care principles in the provision of long-term care services will have a significant impact on this population.
- The Department will have to implement changes in services as a result of Medicaid reform.
- The Department will have to implement operational changes to comply with national standards and advances in information technology.

Service Area Financial Summary

The Medicaid program is funded with a mixture of state and federal funds. The current match rate for Virginia is 50% state and 50% federal funds. The state match for the Medicaid program comes from a combination of the funding from the state General Fund and the Virginia Health Care Fund. The federal funds come from the federal Centers for Medicare & Medicaid Services. In FY2007 and FY2008 the non general funds in the table below are comprised of Federal Funds and the Virginia Health Care Fund.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$1,650,624,011	$2,275,551,782	$1,650,624,011	$2,275,551,782
Changes To Base	($303,949,193)	($485,902,458)	($176,684,562)	($345,555,472)
SERVICE AREA TOTAL	**$1,346,674,818**	**$1,789,649,324**	**$1,473,939,449**	**$1,929,996,310**

Service Area Objectives, Measures, and Strategies

Objective 45609.01

Facilitate access to member healthcare services by building and retaining a sufficient network of diverse providers to deliver covered services

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will ensure enrollees can access services from providers.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Council on Virginia's Future Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families.)

- Promote better health outcomes through prevention-based strategies and improved quality of care.

  (Council on Virginia's Future Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 45609.01.01**

  Number of VA Medicaid enrolled physicians actively submitting claims

  Measure Type: Output **Measure Frequency:** Annually

  Measure Baseline: FY 2004 - 20,410

  Measure Target: FY 2007 - 20,957

  Measure Source and Calculation:
  Source: DMAS Statistical Report, "Number of Providers Receiving Payments from DMAS", File: "provpart-yr"

- **Measure 45609.01.02**

  Number of enrolled dentist in the network

  Measure Type: Output **Measure Frequency:** Quarterly

  Measure Baseline: FY2005 - 620 enrolled dentists

  Measure Target: FY2008 - 890 enrolled dentists

  Measure Source and Calculation:
  The number of enrolled dentists are tracked, reported, and provided to DMAS, Health Care Services Division, by Doral Dental, USA

Objective 45609.01 Has the Following Strategies:

- Identify and target regional areas where provider ratios are unfavorable.
- Review and, if required, implement new policies to assist in increasing provider participation.
- Implement a website with provider enrollment information.

Objective 45609.02

Enhance current systems that monitor quality assurance and program integrity

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will help to

ensure the Medicaid program is as efficient as possible and is protected from fraud and abuse.

This Objective Supports the Following Agency Goals:

- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Council on Virginia's Future #1: To be recognized as the best-managed state in the nation.)

This Objective Has The Following Measure(s):

- **Measure 45609.02.01**

  The number of providers, recipients, and medical record reviews completed each year

  Measure Type: Output **Measure Frequency:** Annually

  Measure Baseline: FY 2004 - 1069

  Measure Target: FY 2007 - 1469

  Measure Source and Calculation:

  Source: QMR (Quality Medical Recovery) reviews are performed and tracked by DMAS, Long Term Care Division. Recipient Audit Unit (RAU) and Provider Review Unit (PRU) reviews are performed and tracked by DMAS, Program Integrity. Calculation: The sum of all reviews comprise the value number.

Objective 45609.02 Has the Following Strategies:

- Identify and target potentially inappropriate billing by providers.
- Review and, if required, implement new policies and/or programs to reduce inappropriate billing.
- Increase use of CS-SURS to identify provider fraud and abuse.
- Refer potential fraud cases to the Medicaid Fraud Control Unit.

Objective 45609.03

Build and sustain an effective and innovative operation that utilizes technology and industry standards

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to improve operational efficiencies.

This Objective Supports the Following Agency Goals:

- Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

  (Council on Virginia's Future Objective #1: To be recognized as the best-managed state in the nation.)

This Objective Has The Following Measure(s):

- **Measure 45609.03.01**

  Percent of clean claims paid in 30 days

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: 100% in FY 2006

  Measure Target: 100% for FY 2007

  Measure Source and Calculation:

  VAMMIS Clean Claim report #MRM325 produces counts and average days that are used to compute the 30 day value percentages.

Objective 45609.03 Has the Following Strategies:

- Identify and target potentially inefficient billing procedures.
- Educate providers on common billing errors.
- Review and, if required, implement new policies and/or procedures to reduce inappropriate billing.

Objective 45609.04

Improve the quality, coordination of care and associated health outcomes to Medicaid/FAMIS participants diagnosed with asthma, diabetes, congestive heart failure and coronary artery disease

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to prevent costly medical procedures and improve quality of care.

This Objective Supports the Following Agency Goals:

- Promote better health outcomes through prevention-based strategies and improved quality of care.
  (Council on Virginia's Future Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 45609.04.01**

  Percentage of eligible clients who are participating in Disease Management

  Measure Type: Output **Measure Frequency:** Quarterly

  Measure Baseline: 9% for Jan 2006

  Measure Target: 15% by Dec 2007

  Measure Source and Calculation:
  Source: H.M.C. contractor report. Calculation: The participation rate is the measure of participation in the care management program among the eligible identified cases. Calculated as Total minus cases closed for Declined All Contact or No Valid Phone/Address. The first available value is Jan 2006. Values are cumulative from January each calendar year. The SFY 06 percentage is Jan-June 2006.

Objective 45609.04 Has the Following Strategies:

- Contract with a disease management program administrator (DMPA) to implement and administer the disease management program.
- Identify, evaluate, and manage the targeted disease state(s) as well as all co-morbid conditions of all participants included in the project.
- Develop strategies, including the development of outreach campaigns, designed to significantly increase knowledge of the program.

Objective 45609.05

We will work to improve the oral health of Medicaid children by increasing the percentage of enrolled children who utilize dental services (KEY)

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to enhance the delivery of healthcare services and increase access to care.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Council on Virginia's Future Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families)

This Objective Has The Following Measure(s):

- **Measure 45609.05.01**

  Percentage of enrolled children who utilize dental services (KEY OBJECTIVE)

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: FY 2005 - 30.44%

  Measure Target: FY 2008 - 40%

  Measure Source and Calculation:
  DMAS claims data are utilized to determine the number of children covered by FAMIS or FAMIS PLUS between the age of three and twenty-one receiving routine dental care visits. This number is divided by the number of children in this age group enrolled in the program. Due to the claim process, final results lag the closing period by about six months.

Objective 45609.05 Has the Following Strategies:

- Administer the Smiles For Children Dental Program effective July 1, 2005.
- Expand the Department's dental provider network, including specialists.
- Develop strategies, including the development of outreach campaigns, designed to significantly increase Medicaid/FAMIS Plus and FAMIS enrollee utilization of pediatric dental services.
- implement an effective case management program with Doral Dental to reduce patient "no shows" and increase overall utilization.

Objective 45609.06

We will work to improve birth outcomes in the Medicaid population by increasing the percentage of Medicaid/FAMIS covered births which are normal birth weight, rather than below normal birth weight (KEY)

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to ensure the effective delivery of covered healthcare services.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Council on Virginia's Future Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 45609.06.01**

  Percentage of Medicaid/FAMIS covered births which are normal birth weight (KEY OBJECTIVE)

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: 90% for FY 2005

  Measure Target: 92% by FY 2008

  Measure Source and Calculation:
  Annual Report conducted each Fall by the contracted external quality review organization (formerly Delmarva Foundation as of SFY 2008, Michigan Peer Review Organization) monitored by Quality Analyst in the Healthcare Services Division
  Unit of Analysis: Based on Health Employer Data and Information Set (HEDIS) methodology for Timeliness of Prenatal Care measure

Objective 45609.06 Has the Following Strategies:

- Develop approaches that will publicize the availability of Medicaid for eligible women so that a higher percentage can begin appropriate prenatal care in their first trimester.
- Streamline Medicaid's administrative and enrollment practices and provide an expedited eligibility process for pregnant women and process their applications within 10 days.

Objective 45609.07

We will work to improve the immunization rate among Medicaid children by increasing the percentage of two year olds in Medicaid who are fully immunized (KEY)

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to improve the level of preventive care and quality of life for young children.

This Objective Supports the Following Agency Goals:

- Promote better health outcomes through prevention-based strategies and improved quality of care.
  (Council on Virginia's Future Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families)

This Objective Has The Following Measure(s):

- **Measure 45609.07.01**

  Percentage of two year olds in Medicaid who are fully immunized (KEY OBJECTIVE)

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: 87% as of FY 2005

  Measure Target: 90% by FY 2008 and up to 91% in FY2009

  Measure Source and Calculation:
  Annual Report conducted each Fall by the contracted external quality review organization (formerly Delmarva Foundation as of SFY 2008, Michigan Peer Review Organization) monitored by Quality Analyst in the Healthcare Services Division
  Unit of Analysis: Based on Health Employer Data and Information Set (HEDIS) methodology for Childhood Immunization Status measure

Objective 45609.07 Has the Following Strategies:

- Track the number of children receiving necessary immunizations.

- Develop education efforts to remind providers of the importance of regular checkups, immunizations, and the need to coordinate patient information flow.

Service Area Background Information

Service Area Description

Provide access to a system of high-quality long-term care services to the elderly and persons with disabilities to ensure health, safety, and welfare.

Service Area Alignment to Mission

By assisting the elderly and persons with disabilities to obtain long-term care services that are of high-quality, cost-effective, and provided in the least restrictive environment that meets their needs.

Service Area Statutory Authority

Title 32.1 Chapter Code of Virginia

Service Area Customer Base

Customer(s)	Served	Potential
Recipients • The elderly and persons with disabilities who meet eligibility requirements	44,554	0

Anticipated Changes In Service Area Customer Base

In fiscal year 2004, the Virginia Medicaid program provided nursing facility care for 27,471 individuals and home and community-based care for 17,083 individuals.

The baby-boomers are aging Medical advances have led to increasing number of persons with chronic conditions and those with developmental disabilities living longer and more productive lives. The Department anticipates the number of customers receiving long-term care services to rapidly increase over the next 15-20 years.

Footnote for Service Area Customer Base Listing:
During the 2006-2008 biennium it is estimated there will be between 850,000 to 1,000,000 individuals enrolled in the Medicaid program at some point during each fiscal year.

Service Area Partners

Advocacy groups

Service Area Partners

Boards and Committees

Service Area Partners

Federal Agencies

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Products and Services

- Long-Term Care & Waiver Programs - Nursing facility care; Home and community-based services

Factors Impacting Service Area Products and Services

The growth of the population of the elderly and persons with disabilities, together with low reimbursement rates which diminish the number of available providers at both the institutional and community level will exert greater pressures on the service delivery system.

Anticipated Changes To Service Area Products and Services

There must be an expansion of community-based care services to address the growing numbers of persons who will likely seek Medicaid-financed long-term care services.

Service Area Financial Summary

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$49,607,580	$49,608,580	$49,607,580	$49,608,580
Changes To Base	$637,951,132	$636,450,132	$674,481,010	$673,463,120
SERVICE AREA TOTAL	**$687,558,712**	**$686,058,712**	**$724,088,590**	**$723,071,700**

Service Area Objectives, Measures, and Strategies

Objective 45610.01

We will work to serve more long-term care clients in the community rather than institutions by increasing the percentage of spending for community based long care services as compared to all Medicaid long term care service expenditures. (KEY)

Given the high and increasing cost of institutional care, DMAS will need to strengthen strategies to encourage the use of less costly and less restrictive home and community based placement.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Council on Virginia's Future Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- Measure 45610.01.01

  Proportion of total Medicaid long term care expenditures for home and community based services (KEY

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: FY 2005 – 34.4%

  Measure Target: FY 2009 – 38%

  Measure Source and Calculation:
  Source: DMAS generated expenditure report (Summary of Medicaid Long Term Care Expenditure Data) from CARS by applicable HCFA/CMS and Home Health category/object codes. Calculation: Home Health costs are divided by HCFA/CMS costs to determine a community long-term care percentage.

Objective 45610.01 Has the Following Strategies:

- Develop a comprehensive automated UAI database that captures information and can be shared across agencies.
- Conduct standardized training for PAS teams on the availability and appropriate use of DMAS' home and community based care waivers.

Objective 45610.02

Ensure access to home and community-based services is provided only to those persons who meet the functional level of care criteria and who utilize waiver services.

Quality management and level of care reviews must demonstrate that only those who meet functional criteria and utilize waiver services remain in the waiver program. Some waiver recipients may use waiver services solely as a route to other Medicaid services (e.g., prescription drug coverage), for which they would not otherwise be eligible but for their enrollment in the waiver program.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Council on Virginia's Future Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families)

This Objective Has The Following Measure(s):

- **Measure 45610.02.01**

  Perform a level of care review on all current eligible waiver recipients

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: FY 2006 - 100%

  Measure Target: FY 2007 - 100%

  Measure Source and Calculation:
  The DMAS data system – LOCRE (Level of Care Review Evaluation System) managed by the Long Term Care Division, tracks all reviews completed.

Objective 45610.02 Has the Following Strategies:

- Train staff to use VAMMIS for purposes of identifying inappropriate waiver use
- Establish process to notify and remove persons from the waiver programs who are inappropriately using these services

Objective 45610.03

Integrate managed care as a service delivery model within the long-term care environment.

Appropriate services can be delivered more effectively through a managed care model. Presently most all long-term care services are paid for through fee-for-service.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 45610.03.01**

  Percent of long-term care recipients who are in managed care

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: 0.4% for FY 2006

  Measure Target: 2.5% for FY 2008

  Measure Source and Calculation:
  Agency data system – VAMMIS
  Number of individuals receiving long term care services through managed care as a percentage of all persons receiving long-term care services.

Objective 45610.03 Has the Following Strategies:

- Market the concept of managed care to stakeholders.
- Design and test the program.
- Implement the program.
- Develop a blueprint for managed care.

Service Area Plan

Department Of Medical Assistance Services

Reimbursements to Acute Care Hospitals Providing Charity Care in Excess of the Median Level of Charity Care Costs (45901)

Service Area Background Information

Service Area Description

The purpose of the Indigent Health Care Trust Fund is to equalize the burden of charity care among non-state-owned hospitals, and to reimburse those among these hospitals with high charity care for part of this cost Note: VCU and UVA hospitals are not included in the trust fund as they are state-affiliated facilities.

Service Area Alignment to Mission

By increasing the funding available for charity care, the Indigent Health Care Trust Fund (IHCTF) increases access to health care for Virginians who qualify under the IHCTF charity care criteria.

Service Area Statutory Authority

The ICHTF was created and is authorized by the Code of Virginia § 32.1-332 et seq. There is no other statutory or regulatory authority governing the IHCTF.

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients	0	0

Anticipated Changes In Service Area Customer Base

The number of uninsured persons below the poverty level is affected by a number of factors, and DMAS does not forecast changes in this number. The Trust Fund's operation is not affected by changes in the customer base. The amount it collects from hospitals, and the amount it pays to other hospitals is fixed by state law, and is not affected by changes in the customer base.

Footnote for Service Area Customer Base Listing:
The exact number of customers is not known. The ICHTF pays some hospitals part of their charity care costs, with the object of reducing but not eliminating the burden on hospitals of providing charity care. The goal is to make hospitals more able to provide charity care, and therefore make charity care more available to all qualifying persons. Therefore, the customers could not include all persons who quality for charity care. Under the terms governing the Trust Fund, this group is made up of persons with income below the poverty level, with no private insurance or Medicaid coverage. The amount of charity care cost incurred by non-state-owned hospitals was $101,038,007 in 2003/2004. The amount of funds paid by the Trust Fund based on this calculation was $7,119,789. Of this, $2,833,058 was collected from other hospitals and $4,285,831 was appropriated from the General Fund.

Service Area Partners

Advocacy groups

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Operations (Financial Services) - DMAS determines the amount individual hospitals pay to or receive from the Trust Fund, and collects and pays these amounts.

Factors Impacting Service Area Products and Services

Changes in the Virginia economy and in employers' propensity to offer health insurance to employees affects the number of persons who may need to depend on charity care that is partially funded by the Trust Fund. However, the operation of the Trust Fund would not be directly affected by such a change.

Anticipated Changes To Service Area Products and Services

None

Service Area Financial Summary

Funding for the IHCTF comes from assessments billed to hospitals and general fund appropriations. For each of FY 2007 and 2008, the hospital funds appropriated are $5 million, and the general funds are $4,285,831. The hospital funds are an estimate, as the final amount depends on the application of a formula to actual hospital data each year. The formula determines which hospitals pay into the IHCTF, and which hospitals will be recipients of the funds.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$4,285,831	$5,000,000	$4,285,831	$5,000,000
Changes To Base	$0	$0	$0	$0
SERVICE AREA TOTAL	**$4,285,831**	**$5,000,000**	**$4,285,831**	**$5,000,000**

Service Area Objectives, Measures, and Strategies

Objective 45901.01

Fund a portion of the charity care provided by Virginia hospitals

There are many persons in Virginia who are medically indigent. While the Trust Fund cannot pay for all the care they need, this goal is to reduce the burden on hospitals by paying for a portion of it.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 45901.01.01**

  Dollars collected from and paid to hospitals

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: 100% for FY 2006

  Measure Target: 100% for FY 2007

  Measure Source and Calculation:

  Source: DMAS generated revenue report from CARS (MR 1671) by IHCTC revenue source code 06250, fund 0242 and the CARS expenses for the same (Budget balance file). Calculation: Revenues (funds collected) are divided by the expenditures paid to determine a percentage of funds used.

Objective 45901.01 Has the Following Strategies:

- Continue to collect and pay funds as required by state law.

Service Area Background Information

Service Area Description

This service pays for 30 minutes of personal care (at $3/day per eligible recipient), for eligible people who receive an Auxiliary Grant. This is a State-only program. The Auxiliary Grant is the state supplement to Supplemental Security Income (SSI), which is paid to eligible individuals who reside in assisted living facilities.

Service Area Alignment to Mission

By assisting people to get additional personal care, we help them get access to health care services.

Service Area Statutory Authority

12VAC30-120-460: Outlines regular assisted living and gives eligibility requirements.

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients	1,579	5,858

Anticipated Changes In Service Area Customer Base

When increases in the Auxiliary Grant are approved, more people could be eligible for Regular Assisted Living services. Increases in the auxiliary grant rate above the normal inflation adjustment are normally authorized through the Appropriation Act.

Service Area Partners

Advocacy groups

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Long-Term Care and Waiver Programs - Long-Term Care Healthcare Services
- Operations (Program Integrity) - Utilization Review
- Provider Enrollment, Services and Reimbursement - Claims Payments

Factors Impacting Service Area Products and Services

The number of providers accepting Auxiliary Grant payments is a factor in the level and quality of care delivered

Anticipated Changes To Service Area Products and Services

None

Service Area Financial Summary

Financial Summary

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$1,612,952	$0	$1,612,952	$0
Changes To Base	($212,952)	$0	($212,952)	$0
SERVICE AREA TOTAL	**$1,400,000**	**$0**	**$1,400,000**	**$0**

Service Area Objectives, Measures, and Strategies

Objective 46105.01

Improve the efficiency of the operation of the regular assisted living (RAL) program

Timely payments need to be made through VaMMIS for RAL recipients who transition between regular assisted living facilities and nursing facilities. The current reimbursement is not sufficient to pay for 30 minutes of personal care. Therefore the program needs to be evaluated and options must be presented to decision makers as to potential modifications to the regular assisted living program and how it interacts with other programs for the target population.

This Objective Supports the Following Agency Goals:

- Enhance the delivery of health care services by improving communication and relationships with customers and partners.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 46105.01.01**

  The number of claims that are paid within established time frames through VaMMIS claims processing

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: 99% FY 2005

  Measure Target: 100% FY 2007 and beyond

  Measure Source and Calculation:

  The data for regular assisted living and nursing facility payments will be captured from VaMMIS and compared to financial transactions currently being processed by the Program Operations Division for regular assisted living and nursing facility residents who transition between these two levels of care. Data will be calculated on a statewide basis.

Objective 46105.01 Has the Following Strategies:

- Program VaMMIS to ensure appropriate payments for regular assisted living and nursing facility residents who transition between regular assisted living and nursing facilities.
- DMAS should work with DSS to evaluate the RAL program and how it interacts with the Auxiliary Grant program and provide policy options to decision makers to improve the effectiveness of the provision of services to this population.

Service Area Plan

Department Of Medical Assistance Services

Reimbursements to Localities for Residents Covered by the State and Local Hospitalization Program (46401)

Service Area Background Information

Service Area Description

This service area provides coverage for inpatient and outpatient hospitalization, ambulatory surgical centers and local health department clinic visits to eligible, indigent Virginians who are not eligible for Medicaid. A person may be eligible for the State and Local Hospitalization (SLH) Program whether employed or unemployed, insured or uninsured, if the person meets the income and resource criteria established for the program. SLH is not an entitlement program. Once a locality's funds are exhausted, no further benefits are offered until the next year's allocation is received.

Service Area Alignment to Mission

Individuals determined eligible for services under the program are provided access to high quality and cost effective health care services

Service Area Statutory Authority

Title 32.1, Chapter 12, Code of Virginia

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients	6,101	12,789

Anticipated Changes In Service Area Customer Base

The number of recipients served through SLH has declined 11 percent over the past five years. This trend is likely to continue due to the rising cost of medical services and the capped level of funding in the program

Footnote for Service Area Customer Base Listing:
Individuals may qualify for the State and Local Hospitalization program if they do not qualify for full Medicaid benefits, have countable income equal to or less than 100 percent, and have resources equal to or less than the then current resource standards of the federal Supplemental Security Income Program.

This figure represents the number of clients who were enrolled and had claims paid plus the number of clients enrolled with no claims paid because funds were exhausted. The potential customer base would be higher if funding were increased. Local Departments of Social Services are required to take applications until October 30th each year. If funds are exhausted after that date, no additional applications are taken. Many localities exhaust their funds on or before this date, therefore, the potential client base is higher than indicated.

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Special Programs - Coverage for Inpatient and Outpatient Hospitalization, Ambulatory Surgical Centers and Health Department Clinic Visits
- Operations (Financial Services) - Rate Setting; Calculation of Locality Allocations, Billing Localities and Collecting Locality Share
- Operations (Provider Enrollment, Services and Reimbursement) - Claims Processing

Factors Impacting Service Area Products and Services

The following factors will impact the services provided within this service area:
- Limited funding for the program, which has not increased since the inception of the SLH program in FY90
- Health care cost inflation
- Implementation of Diagnostic Related Groups (DRG - a reimbursement payment methodology) in FY04 resulted in higher reimbursements per hospitalization. Therefore, fewer clients were able to receive services

Anticipated Changes To Service Area Products and Services

Regulatory changes are anticipated that will remove the eligibility determination requirement that bases the income and resource methodology on the former cash payment program Aid to Dependent Children (ADC). This policy is cumbersome for the Local Department of Social Services workers who determine eligibility, as ADC policy is no longer in existence. Additional policy changes are anticipated that will allow women determined eligible for limited Medicaid coverage under Family Planning Services to also be evaluated and enrolled in SLH. Currently, anyone eligible for Medicaid cannot be enrolled in SLH.

Service Area Plan

Department Of Medical Assistance Services

Reimbursements to Localities for Residents Covered by the State and Local Hospitalization Program (46401)

Service Area Financial Summary

The SLH program is financed entirely by state and local funds with the state providing at least 75% of the cost by allocating the amount of funds appropriated to each locality on the basis of current estimated demand for covered services. Funds allocated to a locality can be used to pay for services provided to residents of that locality only.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$10,865,779	$2,800,000	$10,865,779	$2,800,000
Changes To Base	$0	$0	$0	$0
SERVICE AREA TOTAL	**$10,865,779**	**$2,800,000**	**$10,865,779**	**$2,800,000**

Service Area Objectives, Measures, and Strategies

Objective 46401.01

Ensure transactions are processed in an accurate and timely manner

Accurate and timely processes prevent costly rework.

This Objective Supports the Following Agency Goals:

- Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

  (To be recognized as the best-managed state in the nation)

This Objective Has The Following Measure(s):

- **Measure 46401.01.01**

  Percent of funds expended at the end of program period.

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: 98.6% as of April 2006

  Measure Target: 98% FY 2007

  Measure Source and Calculation:

  Source: DMAS generated expenditure report from CARS (Budget balance file) by program 46401 for funds 0100 and 0204. In addition, the budgeted amounts for this is obtained from the Appropriation Act. Calculation: Expenditures are divided by the budget to determine a percentage of funds used.

Objective 46401.01 Has the Following Strategies:

- Examine the billing instructions and the SLH manual for improvement opportunities.

Service Area Plan

Department Of Medical Assistance Services

Insurance Premium Payments for HIV-Positive Individuals (46403)

Service Area Background Information

Service Area Description

This service area ensures that HIV clients are able to maintain their medication protocol. The program provides reimbursement for health insurance premium payments to ensure that those approved individuals are able to maintain and utilize their private health insurance.

In order to qualify an individual must be 1) a resident of Virginia, 2) able to provide documentation from a physician verifying disability within three months due to HIV+ diagnosis, and 3) eligible for and have availability of continuing health insurance. DMAS determines eligibility for the program and assumes the responsibility of providing health insurance premium payment in a timely manner

Service Area Alignment to Mission

By providing financial assistance for recipients' health insurance premiums, the program enables recipients to maintain maximum comprehensive health care benefits and deflect the expenses away from the Medicaid program. If these individuals do not maintain their private health insurance coverage they will likely become Medicaid eligible due to the significant costs for HIV pharmacy products.

Service Area Statutory Authority

Code of Virginia § 32.1-321.2 through 32.1-321.4,and § 63.1-124

Service Area Customer Base

Customer(s)	Served	Potential
Clients / Beneficiaries -- Low-income, aged, or disabled Virginians	78	0

Anticipated Changes In Service Area Customer Base

The Department expects the number of eligible enrollees to increase. There are many individuals who are already eligible, but have not heard of the program nor applied for it because their case managers were aware of the waiting list. The waiting list is necessary due to the capped amount of funding.

Service Area Partners

Advocacy groups

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

State government officials

Service Area Products and Services

- Special Programs - financial assistance for health insurance premiums

Factors Impacting Service Area Products and Services

The services provided by the HIV Unit are extremely important to eligible enrollees and is limited only by funding options. There has always been a waiting list and the funding for this area needs to increase on an annual basis. There is a growing need for insurance continuation for this population as the drug therapies improve. Complicating this situation is the fact that premiums for commercial insurance have been increasing yearly at double- digit rates.

Anticipated Changes To Service Area Products and Services

The Department does not anticipate any changes to the products and services.

Service Area Financial Summary

The HIV Premium Assistance Program is funded with 100% state General Funds.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$556,702	$0	$556,702	$0
Changes To Base	$0	$0	$0	$0
SERVICE AREA TOTAL	**$556,702**	**$0**	**$556,702**	**$0**

Service Area Objectives, Measures, and Strategies

Objective 46403.01

Maximize the potential of the program to cover as many eligible individuals as possible within available funding

Enrollment in this program provides vital continuing healthcare for eligible individuals at a lower cost to the state.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Council on Virginia's Future Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families)

This Objective Has The Following Measure(s):

- **Measure 46403.01.01**

  Percent of available funds expended

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: FY 2005 - 99.1%

  Measure Target: FY 2007 - 99% or greater

  Measure Source and Calculation:

  Source: DMAS generated expenditure report from CARS (Budget balance file) by program 46403 for funds 0100 and 0204. In addition, the budgeted amounts for this is obtained from the Appropriation Act Calculation: Expenditures are divided by the budget to determine a percentage of funds used

Service Area Plan

Department Of Medical Assistance Services

Reimbursements from the Uninsured Medical Catastrophe Fund (46405)

Service Area Background Information

Service Area Description

This service area provides payment for medical services to eligible, uninsured Virginians diagnosed with a life-threatening medical catastrophe. Eligibility is based on income, legal residency in the Commonwealth of Virginia, life threatening injury or illness and an approved treatment plan. Applications are taken on a first come, first served basis.

Service Area Alignment to Mission

Individuals determined eligible for services under the program are provided access to life-saving health care services.

Service Area Statutory Authority

Code of Virginia §32.1-324.3 and § 32.1-325

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients	6	0

Anticipated Changes In Service Area Customer Base

With a new, dedicated staff position for this program, current initiatives to streamline the regulations and application process, and additional funding provided for fiscal year 2006, it is anticipated that the number of individuals served through the Uninsured Medical Catastrophe Fund will increase in future years to the extent that funding is available.

Footnote to Service Area Customer Base Listing:
Six applicants were approved in SFY05 and provider agreements received; however, funds have only been disbursed for one applicant. Invoices are pending for the remaining five applicants.

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Special programs - Life-saving health care services based on Medicaid rates
- Operations (Enrollment and Member Services) - Determine eligibility, approve treatment plan, and determine treatment plan costs.
- Operations (Provider Enrollment, Services and Reimbursement) - Contract with providers for services approved on the treatment plan; verify services rendered and initiate payment to the provider.

Factors Impacting Service Area Products and Services

There a number of administrative and operational factors that affect the products and services of the UMCF, including application requirements, provider agreements and requirements, payment methodology, regulatory restrictions and limited funding. The Department intends to streamline the administrative/operational aspects of the program to make it more effective and less difficult to administer

Anticipated Changes To Service Area Products and Services

A dedicated staff person was recently hired to review and analyze program barriers, and to develop recommendations from workgroups and interested advocacy groups to streamline current processes and implement improvements. Program information sheets disseminated to advocacy groups and available on the Internet will be updated to clarify the current program requirements that have resulted in confusion with services received prior to a signed Provider Agreement.

Service Area Financial Summary

The program was funded entirely with private contributions and donations until FY 06 when the General Assembly allocated $125,000 in one time funding for the program. These funds were placed in DMAS' administrative budget to be transferred to the UMCF.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$0	$0	$0	$0
Changes To Base	$0	$0	$0	$0
SERVICE AREA TOTAL	**$0**	**$0**	**$0**	**$0**

Service Area Objectives, Measures, and Strategies

Objective 46405.01

Facilitate access to health care services to qualified uninsured Virginians who have been diagnosed with a life-threatening injury or illness

Uninsured individuals cannot always access required medical services to treat life-threatening injuries or illness. This program allows eligible individuals to receive medical treatment for a condition that otherwise left untreated, could result in death.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 46405.01.01**

  Percent of completed applications processed within 60 days

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: 100% in FY 2006

  Measure Target: 100% in FY 2007

  Measure Source and Calculation:
  Source: DMAS Program Operations Division tracking document of initial applications and approval/denial documents.
  Calculation: Number of applications approved within 60 days/total applications

Objective 46405.01 Has the Following Strategies:

- Review and streamline application processes to accommodate for the timeliness necessary for life-threatening conditions.
- Explore the creation of a pre-approved regional list of providers willing to provide treatment under the conditions of the UMCF.
- Educate and contact providers before a medical crisis occurs with information on both the UMCF and instructions to properly complete patient treatment plans in order to prevent costly delays.

Service Area Background Information

Service Area Description

The expansion of Medicaid eligibility for uninsured children from age 6 to 19 is part of Virginia's Title XXI program for uninsured children living below 200% of the federal poverty level (FPL). Prior to this expansion, children under age 6 could qualify for Medicaid benefits with family income up to 133% FPL but children from 6 to 19 would only qualify for Medicaid with income less than or equal to 100% FPL. Children from 6 to 19 with income between 100% FPL and 133% FPL might qualify for the FAMIS program instead; but this meant children in the same family would be enrolled in different programs and families would have to navigate two different systems of care. In September 2002, Virginia's Title XXI program was split into FAMIS for children 0 - 19 with income greater than Medicaid but less than or equal to 200% FPL; and the SCHIP Medicaid Expansion for children age 6 - 19 with income greater than 100% FPL but less than or equal to 133% FPL. Children covered by the SCHIP Medicaid Expansion receive full Medicaid benefits but are funded through Title XXI at a lower state-matching rate Than Title XIX (Medicaid).

In 2004, The Virginia General Assembly renamed Medicaid for children, including the SCHIP Medicaid Expansion program, to FAMIS Plus.

Service Area Alignment to Mission

The SCHIP Medicaid Expansion carries out the mission of DMAS by providing access to a comprehensive system of high quality and cost effective health care services to uninsured children age 6 to 19 with income between 100% FPL and 133% FPL.

Service Area Statutory Authority

CFR: 42 part 457
Code of Virginia §32.1-351

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients: Uninsured children age 6 to 19 with family income greater than 100% FPL and less than or equal to 133% FPL	57,658	0

Anticipated Changes In Service Area Customer Base

The customer base of children eligible for the SCHIP Medicaid Expansion program is likely to remain approximately the same for the next several years. Factors that could affect the number of customers would include a downturn in the Virginia economy, private insurance market forces that result in an increase in rates of uninsurance, a significant increase in the 6 to 19 population, or policy changes affecting program eligibility.

Footnote for Service Area Customer Base Listing:
Number of children served at anytime during FY 2005.

It is currently estimated that approximately 16,000 children could qualify for Medicaid (including the SCHIP Medicaid Expansion) or FAMIS but are not enrolled. It is unknown how many of these children would qualify for the SCHIP Medicaid Expansion.

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Federal agencies

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- SCHIP Medicaid Expansion
  - Coverage for comprehensive health care services through managed care or fee-for-service
  - Marketing and outreach to promote enrollment
  - Application processing and enrollment
  - Claims payment

Factors Impacting Service Area Products and Services

Federal and state appropriations and regulations impact the nature and scope of the services that can be provided through the SCHIP Medicaid Expansion. Unlike Medicaid, the SCHIP Expansion is not an entitlement program

Anticipated Changes To Service Area Products and Services

Congress must reauthorize Title XXI no later than September 30, 2007. It is likely the federal funding formula that determines Virginia's annual allotment will be revised.

Service Area Financial Summary

The Medicaid expansion program is covered with a mixture of state and federal funds. On the federal level this program is covered through the Title XXI SCHIP program that provides an enhanced federal match rate. The current match rate for Virginia is 35% state and 65% federal funds. The state match for the Medicaid expansion program comes from the state General Fund. The federal funds come from the federal Centers for Medicare & Medicaid Services.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$20,615,213	$39,772,726	$20,615,213	$39,772,726
Changes To Base	$2,888,827	$3,877,503	$5,745,362	$9,182,627
SERVICE AREA TOTAL	**$23,504,040**	**$43,650,229**	**$26,360,575**	**$48,955,353**

Service Area Objectives, Measures, and Strategies

Objective 46601.01

Enroll all eligible children in the SCHIP Medicaid Expansion program

While enrollment of eligible children in the SCHIP Medicaid Expansion program has increased dramatically, there are still uninsured children who could be covered and additional children who become uninsured every day. It is in the best interest of the children, their families and the Commonwealth to provide comprehensive health care coverage through the SCHIP Medicaid Expansion to this vulnerable population.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 46601.01.01**

  Number of eligible children enrolled in FAMIS or FAMIS Plus

  Measure Type: Output **Measure Frequency:** Quarterly

  Measure Baseline: FY 05 - 416,548

  Measure Target: FY 06 and beyond - 430,878

  Measure Source and Calculation:

  Data Source: Data from VAMMIS on the number of children enrolled in the SCHIP Medicaid Expansion on the first day of each month, following all cancellations that occur on the last day of each month, will be reported. This number will be combined with enrollment data for all children enrolled in FAMIS Plus (Medicaid) and FAMIS and compared to the number of children estimated to be eligible for publicly supported health insurance in Virginia for a percentage of overall enrollment.

  Calculation: Estimates of eligible children are calculated by a formula based on Census data, poverty rates by locality and results of the 2000 Health Access Survey conducted by the Virginia Health Care Foundation. This formula is recalibrated periodically as current data become available (the last updates were made in January 2002 and January 2004).

Objective 46601.01 Has the Following Strategies:

- Develop and implement a general marketing campaign specifically designed to reach families with eligible children.
- Develop outreach activities and materials to reach traditionally "hard-to-reach" populations.
- Increase the use of technology to improve customer service for interested families and to facilitate application processing and enrollment.

Objective 46601.02

We will work to improve oral health and increase the utilization of appropriate preventive care by children enrolled in the SCHIP Medicaid Expansion (KEY)

Approximately 55,000 children have been served through the SCHIP Medicaid expansion program in FY 2005. This objective will focus DMAS' efforts to improve health outcomes for children and reduce long-

term health care costs by improving the timely and appropriate utilization of preventive health care services.

This Objective Supports the Following Agency Goals:

- Promote better health outcomes through prevention-based strategies and improved quality of care.
  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 46601.02.01**
  Percentage of SCHIP Medicaid expansion enrolled children who utilize dental services (KEY OBJECTIVE

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: 30 44% for FY 2005

  Measure Target: 40% in FY 2008

  Measure Source and Calculation:
  The HFCA 416 Report submitted annually to CMS captures dental claims data on children enrolled in Medicaid by age group. While the SCHIP Medicaid Expansion population is not separated out from the total number of children covered by Medicaid on this report, the rates of preventive dental care services do include this population. The age groups from age 6 to 19 are utilized to report approximate preventive dental care rates for this population. Due to the claim process, final results lag the closing period by about six months.

- **Measure 46601.02.02**
  EPSDT well-child screenings (KEY OBJECTIVE)

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: CY 2004 - 23% of children ages 7 - 11 (and 21% of children ages 12 - 18)

  Measure Target: FY 2008 - 50% overall compliance

  Measure Source and Calculation:
  DMAS contracts with an EQRO vendor to study and produce an annual report related to the utilization of appropriate well child visits by the SCHIP population. Both administrative claims data from VAMMIS and medical record data are reviewed. The rate of 7 - 11 year old children receiving recommended well-child visits and the rate of 12 - 18 year old children is determined by comparing the number of children in each age group receiving one or more well-child visits during the study period to the total number of covered children in each age group.

Objective 46601.02 Has the Following Strategies:

- Promote utilization of EPSDT (well-child screenings) covered by Medicaid and remind providers of the importance of regular checkups, immunizations, and the coordination of information.
- Promote utilization of preventive pediatric dental visits by children covered by Medicaid.

Service Area Plan

Department Of Medical Assistance Services

Administrative and Support Services (49900)

Service Area Background Information

Service Area Description

This service area includes the manpower, administrative support, policy and research and contractual services necessary to successfully operate the Agency's programs and activities.

Service Area Alignment to Mission

Our system of administrative support to all the operational areas of the agency allows us to provide access to a comprehensive system of high quality and cost effective health care services to qualifying Virginians.

Service Area Statutory Authority

Title 32.1, Chapters 9 &10, Code of VA: PL89-87m, as amended, Title 19, Social Security Act, Federal Code

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients	832,905	0

Anticipated Changes In Service Area Customer Base

In order to keep pace with and better serve the increasing eligible population, there is a need to increase the Agency's maximum employment level to reduce our dependence on the use of hourly and contract personnel.

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Federal agencies

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Operations (Financial Services) - Fiscal Services
- Operations (Policy Analysis and Information Dissemination) -Communications and Legislative Liaison Services
- Operations (Information Management)
- Operations (Program Integrity) - Internal Audit Services
- Operations (Provider Enrollment, Services and Reimbursement) - Provider Reimbursement Services
- Appeals - Client Appeals and Provider Appeals of Audits and Other Adverse Agency Decisions
- Administration - Human Resources Services & Training
- Operations (Program Integrity) -Quality Assurances Services
- Operations (Enrollment and Member Services, Provider Enrollment, Services and Reimbursement) -Appeals Services
- Operations (Policy Analysis and Information Dissemination) - Policy and Research Services

Factors Impacting Service Area Products and Services

Projects related to the work of DMAS operational areas determine the work that is performed in the administrative divisions. Changes in administrative services are the result of significant operational projects, including the Medicare Prescription Drug Program, Medicaid Reform, Electronic Health Records, Disease Management Program, and the National Provider Identifier project.

Anticipated Changes To Service Area Products and Services

The Department must be flexible and adapt to new programs and priorities in order to best meet recipient service needs. It is critical that the agency's MEL be increased in order to continue current programs and implement significant new functions.

Service Area Human Resources Summary

Service Area Human Resources Overview

The Department of Medical Assistance Services is a highly professional organization with 348 authorized classified positions. As of October 10, 2006, 318 of these positions are filled and 36 are vacant. Four of the classified employees are located in the Roanoke Office; one is located in Manassas, and one is in Virginia Beach. Because of increasing program requirements, the Department has had to use increasing numbers of hourly employees. Most of the contract employees work in the Information Management Division and play a critical role in the maintenance of the Virginia Medicaid Management Information System and any programmatic changes. The Department has 15 divisions/offices, which include the Office of the Director. Forty-one role titles are used and the most prevalent are the Health Care Compliance Specialist II (18.4%), Health Care Compliance Specialist I (13.5%), Administrative and Office Specialist III (11.6%), and Program Administration Specialist II (12.3%). We also employ workers from temporary employment agencies, such as Caliper.

Additional Information for the Human Resource Levels Tab:
Temporary Agency Workers - 5

Service Area Full-Time Equivalent (FTE) Position Summary

Effective Date: 10/10/2006

Total Authorized Position level	348
Vacant Positions	30
Non-Classified (Filled)	3
Full-Time Classified (Filled)	315
Part-Time Classified (Filled)	0
Faculty (Filled)	0
Wage	84
Contract Employees	27
Total Human Resource Level	**429**

Factors Impacting Service Area Human Resources

Increased programmatic requirements continue to necessitate the extensive hiring of hourly employees. The hourly employees serve a vital role and require the same level of training as full-time employees. However, most of these employees seek other employment with benefits. Thus, the turnover rate among the hourly workforce for this reporting period was 40.8%. The restriction of 1500 work hours per year for hourly workers also has a negative impact on productivity and retention.

There is some concern regarding the aging workforce. The average age of the DMAS classified workforce is 47 years. As of October 10, 2006, eleven (11) employees are eligible for full retirement being age 50 with 30 years of service; four additional employees can retire with full benefits based on age. Ninety-four (94) employees (30%) are age 50 with 10 years of service and could retire with partial benefits, although most employees prefer to retire with full benefits. The positions range from upper level management to support staff. During the next five years, an additional four (4) employees will become eligible for full retirement. These figures do not include employees who have purchased prior service and may be eligible for retirement much sooner.

The turnover rate for classified employees leaving the Department during the October 10, 2005 to October 10, 2006 period was 14 % (45) Most of these employees left the Department for advancement reasons. Of this number, 10 left the State, 15 transferred to other state agencies, 12 retired, 6 were terminated based on the Standards of Conduct Policy, and two are deceased.

Anticipated Changes in Service Area Human Resources

Due to budget constraints, employee training has received little emphasis in past years. However, a full-time classified position was recently approved and has been filled. This position is responsible for both training and the employment process. With adequate funding, it is hoped that not only will the employee training program be enhanced, but the time frames for filling positions will be expedited. To date, DMAS is increasing the amount of employee training opportunities. Currently, a series of classes on customer service, project management, supervisory/leadership, and computer software training has been presented during the last fiscal year. This type of training is being scheduled for future training during the current fiscal year. In addition, it is planned to continue the DMAS Supervisory and Leadership Institute presented by the Community College Workforce Alliance; it will begin November 1, 2006 with a series of comprehensive supervisory and leadership classes.

We anticipate greater use of the Learning Management System both internally and with the programs offered by the Department of Human Resource Management. The Learning Management System is a Web-based system designed to present learning and knowledge sharing opportunities to its users. It promotes

learning through online course offerings, classroom course registration, and a consolidated transcript of all learning events for individual users. The system DMAS has purchased is the Meridian KSI Knowledge Center (TM), but it is mainly used for provider training. Currently, we are members of the DHRM LMS Users group and will be implementing on-line access to the DHRM LMS Knowledge Center.

It is anticipated that there will be improvement in automated databases provided by the Department of Human Resource Management and the Department of Accounts.

The Maximum Employment Level was recently raised to 348 positions, but there is a continuing need to use hourly employees to meet programmatic needs. Of the current thirty-six (36) vacant classified positions, all are either in some stage of the recruitment and selection process or under classification review. A high frequency rate of internal transfers and promotions seems to keep the vacancy rate consistently high.

Even though the turnover rate is not as high in DMAS as in some other agencies, retention of highly skilled employees must be emphasized through effective employee recognition programs, training, and fair and consistent compensation practices.

Service Area Financial Summary

DMAS' total administrative funding consists of federal funds and state general (GF) funds. There are also several small grants that are paid from non-general funds (NGF). For fiscal year 2007, $36.5 million in funding, or 37%, is from GF and $ 61.5 million, or 61%, in funding is from federal funds and other NGF.

In addition, DMAS manages the FAMIS administrative program. In fiscal year 2007, $2.6 million in funding is from GF, and $4.7 million in funding is from federal funds.

DMAS also serves as the pass-through agency for the transfer of federal funding to the Department of Social Services for Medicaid eligibility determinations. These amounts and smaller pass-throughs to four other state agencies are not in the base budget figures. All requested changes to the base budget will be documented in the decision package, base adjustment and technical adjustment submissions in August and September.

In FY2007 and FY2008 non general funds is composed of Federal Funds and special fund Civil Money Penalties.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$31,715,960	$50,682,598	$31,715,960	$50,682,598
Changes To Base	$4,815,913	$10,836,357	$4,839,656	$8,536,694
SERVICE AREA TOTAL	**$36,531,873**	**$61,518,955**	**$36,555,616**	**$59,219,292**

Service Area Objectives, Measures, and Strategies

Objective 49900.01

Improve communication among employees throughout the agency

This will enable the department to develop more effective methods of communication within and between divisions that, in turn, will contribute towards ensuring a comprehensive system of high quality and cost effective health care services.

This Objective Supports the Following Agency Goals:

- Create a positive work environment that promotes staff development and training, facilitates effective communications and rewards high levels of performance.

  (To be recognized as the best-managed state in the nation)

This Objective Has The Following Measure(s):

- **Measure 49900.01.01**

  The degree to which employees feel communications are effective

  Measure Type: Outcome **Measure Frequency:** Every Six Months

  Measure Baseline: FY 2006 - median percentage of 75%

  Measure Target: FY 2007 - median percentage of 79%

  Measure Source and Calculation:
  The degree to which employees feel communications are effective as measured by the employee survey

Objective 49900.01 Has the Following Strategies:

- Design, administer and analyze the results of an employee survey.
- Implement a communication plan based on results of survey.
- Conduct a follow-up assessment of communication within the department six months after any changes.

Objective 49900.02

Recruit, develop and retain a skilled, diverse and adequately sized, professional workforce

A highly skilled and stable workforce is essential for meeting the goals and mission of the Department. To ensure such a workforce is in place, the Department needs a recruitment process that will attract the highest level of skilled candidates and retain these workers once hired. In addition, The Department needs a recognition program that contributes to a positive work environment.

This Objective Supports the Following Agency Goals:

- Create a positive work environment that promotes staff development and training, facilitates effective communications and rewards high levels of performance.

  (To be recognized as the best-managed state in the nation.)

This Objective Has The Following Measure(s):

- **Measure 49900.02.01**

  Employee turnover rate

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: 11.5% for FY 2005

  Measure Target: 8.0% for FY 2007

  Measure Source and Calculation:
  DMAS tracking and reporting within the H.R. Division based on the Recruitment and Selection Log Analysis and Human Resources Transaction Log Analysis

Objective 49900.02 Has the Following Strategies:

- Redesign and implement an exit interview process that better captures reasons for employee resignations.
- Develop effective and consistent rewards, incentives and recognition to improve employee morale and better recognize outstanding performance.
- Design and implement a system to effectively train and develop staff.
- Design, administer and analyze the results of an employee survey.
- Revise the recognition program, as needed, based on survey results.
- Maintain a record of awards and analyze for consistency and cost between divisions.
- Prepare and analyze quarterly reports that include selection and turnover data as well as exit interview results.

Objective 49900.03

Safeguard and protect the assets of the agency, ensuring that incidents of fraud, waste and abuse are identified and reduced

The purpose of this goal is to protect taxpayer assets in the custody of DMAS and to optimize their employment through a system of controls designed to prevent, detect and eliminate financial and other irregularities such as waste, loss, and unauthorized use or misappropriation.

This Objective Supports the Following Agency Goals:

- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (To be recognized as the best-managed state in the nation.)

This Objective Has The Following Measure(s):

- **Measure 49900.03.01**

  DMAS achievement of an audit score of no less than 85.00 out of a possible 100.00

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: No less than 85%

  Measure Target: 90% or above in FY 2007

  Measure Source and Calculation:
  Source: In November of each year, the outcome of IA concurrent testing performed within Internal Audit's Business Process Review System is reported in the Internal Audit Annual Report.
  This measure is calculated based on the cumulative overall quantitative score results from: 1. outstanding APA findings, 2. results of Control Self Assessments, and 3. outstanding Internal Audit findings and IA testing of the outcome of quality assurance assessments of providers and recipients.
  Findings are assigned a risk level that is then multiplied by the number of years since the audit to produce a value for the outstanding finding. The values for all outstanding findings are totaled and subtracted from a possible score of 100%. For business process scoring, individual tests is assigned a factor weight. Each test is scored on the basis of 1 to 100. The weighted score for each test is the percent correct multiplied by the factor weight.

- **Measure 49900.03.02**

  The degree to which financial statements and reports are free of material misstatement

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: No less than 85%

  Measure Target: 90% or above in FY 2007

  Measure Source and Calculation:
  Source: In November of each year, the outcome of IA concurrent testing performed within Internal Audit's Business Process Review System is reported in the Internal Audit Annual Report.
  This measure is calculated based on the cumulative overall quantitative score results from outstanding APA findings.
  Findings are assigned a risk level that is then multiplied by the number of years since the audit to produce a value for the outstanding finding. The values for all outstanding findings are totaled and subtracted from a possible score of 100%.

Objective 49900.03 Has the Following Strategies:

- Conduct concurrent audits of DMAS business processes (DMAS Internal Audit); thoroughly investigate all hot line tips.
- Follow through on findings of 1) annual audits of the DMAS financial statements and the DMAS system of internal control conducted by the Virginia Auditor of Public Accounts, 2) quarterly reviews of DMAS operations conducted by CMS and other Federal oversight agencies, and 3) DMAS concurrent audits.
- Strengthen the current system of internal controls designed to prevent waste, loss, unauthorized use and misappropriation of Agency resources.
- Perform periodic vulnerability assessments and implement process/system changes based on vulnerability assessment findings.

- Ensure adequate standards of business conduct are being observed and financial statements and reports comply with generally accepted business standards.
- Ensure the timely and accurate posting of data into Agency systems.

Objective 49900.04

Ensure programs are evaluated and monitored for operational effectiveness and efficiency

DMAS is under an obligation to Virginia taxpayers to operate its programs so as to maximize its use of taxpayer provided resources while delivering the highest quality of care those resources will command.

This Objective Supports the Following Agency Goals:

- Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

  (To be recognized as the best-managed state in the nation.)

This Objective Has The Following Measure(s):

- **Measure 49900.04.01**

  The number of incidents involving operational inefficiency/ineffectiveness reported by audit entities

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: No less than 85%

  Measure Target: 90% or above in FY07

  Measure Source and Calculation:

  Source: In November of each year, the outcome of IA concurrent testing performed within Internal Audit's Business Process Review System is reported in the Internal Audit Annual Report.

  This measure is calculated based on the cumulative overall quantitative score results from the outstanding Internal Audit findings and IA testing of the outcome of quality assurance assessments of providers and recipients.

  For business process scoring, individual tests is assigned a factor weight. Each test is scored on the basis of 1 to 100. The weighted score for each test is the percent correct multiplied by the factor weight.

Objective 49900.04 Has the Following Strategies:

- Conduct quality assurance and concurrent audits.
- Resolve all audit findings identified by the Virginia Auditor of Public Accounts
- Perform regularly concurrent tests of program operations based on risk assessment.

Objective 49900.05

Process transactions in a timely and accurate manner in accordance with all HIPAA standards

Transactions are to be promptly and accurately recorded and classified in accordance with Agency guidelines and are 100% compliant with HIPAA standards.

This Objective Supports the Following Agency Goals:

- Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

  (To be recognized as the best-managed state in the nation.)

This Objective Has The Following Measure(s):

- **Measure 49900.05.01**

  Percent of audited transactions processed within time standards

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: 100% FY 2006

  Measure Target: 100% FY 2007

  Measure Source and Calculation:
  The DMAS system "CLAREDI" is compliance checker software that checks files for compliance with the transactions sets before the files are input into the MMIS. When non-compliant transactions are detected, they are rejected to the sender and must be corrected and resubmitted. FHSC retains logs of rejected transactions.

Objective 49900.05 Has the Following Strategies:

- Establish and communicate the appropriate authorization and execution of transactions in accordance with Agency guidelines and internal controls.
- Perform monthly reconciliation between general ledger accounts, subsidiary ledgers, source documentation, claim submissions, etc to determine improper and untimely recording of transactions; Agency staff should perform periodic review and testing of transactions to determine how long (timeliness) it takes for transactions to be processed – from receipt to classification in Agency systems.
- Implement and/or adjust procedures to prevent the recurrence of process inefficiencies based on the evaluation of monthly reconciliations and periodic reviews.
- Increase productivity through process and technology improvement.
- Compare DMAS programs and policies against other best practices in the nation.
- Establish list of HIPAA transaction "Benchmarks."
- Analyze the results of DMAS comparison of standard against the established benchmark.
- Acknowledge compliance or improve standards based on results of comparison.

Objective 49900.06

To ensure that resources are used efficiently and programs are managed effectively, and in a manner consistent with applicable state and federal requirements

To ensure that resources are used efficiently and programs are managed effectively, and in a manner consistent with applicable state and federal requirements.

This Objective Supports the Following Agency Goals:

- Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

  (To be recognized as the best-managed state in the union.)

This Objective Has The Following Measure(s):

- **Measure 49900.06.01**

  Percent of Governor's Management scorecard categories marked as meets expectations for the agency

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: 80% for FY 2005

  Measure Target: 100% for the 2007 Scorecard

  Measure Source and Calculation:
  Data Source: The Management Scorecard grades agencies on five criteria: Human Resource Management, Government Procurement, Financial Management, Technology, and Performance Management (the sixth, "Environmental & Historic Resource Stewardship" was not measured in 2005). The measure is calculated by taking the number of criteria where the agency scored "Meets Expectations" and dividing by the criteria.

Objective 49900.07

Increase the Agency's utilization of small, women-owned and minority businesses (SWaM)

This objective will allow the agency to align itself with the Governor's initiative of increasing SWaM participation throughout the Commonwealth.

Alignment:
Encouraging support of minority business development throughout the Commonwealth and strive to continue improving direct and indirect minority business relationships in the future.

To be recognized as the best-managed state in the nation.

This Objective Supports the Following Agency Goals:

- Encouraging support of minority business development throughout the Commonwealth and strive to continue improving direct and indirect minority business relationships in the future.

This Objective Has The Following Measure(s):

- **Measure 49900.07.01**

  Percentage of agency's discretionary contracting and purchasing through SWaM vendors

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: 4.4% in FY 2006

  Measure Target: 5.0% for FY 2007

  Measure Source and Calculation:
  Source: Agency Quarterly SWaM Expenditure Report as provided on the DMBE (Department of Minority Business Enterprises) Supplier Diversity Expenditure Report.
  The measure of SWaM purchasing and contracting is calculated in accordance with the procedures adopted by the Department of Minority Business Enterprises (DBME).

Objective 49900.07 Has the Following Strategies:

- Work with DMBE to streamline the certification process for vendors not registered with DMBE.

- Pursue multiple sources (e.g. DMBE, Internet, newspaper) on a regular basis to identify SWAM vendors that provide the goods and services needed for ongoing operations
- Annually submit an aggressive SWAM Plan with goals of increasing SWAM participation from one fiscal year to the next.
- Work with DBME to develop a reporting process which more accurately reflects the agency's SWAM efforts

Objective 49900.08

Provide a client and provider appeal process and issue resulting decisions that comply with procedural and substantive requirements of state and federal laws, regulations, policy, and court orders.

This objective is mandated by law. Client appeals are governed generally by 42 CFR § 431.200 et. seq. (Fair Hearings for Applicants and Recipients.) There is also a court order (Shifflett v. Kozlowski) that sets forth certain requirements for the Department's client appeals, such as that 97% of decisions must be issued within 90 days from receipt of the appeal request. Provider appeals are governed generally by Va. Code § 2.2-4000 et seq. (Administrative Process Act). There are also requirements in Va. Code § 32.1-325.1 regarding the issuance of 100% of initial provider appeal determinations within 180 days from receipt of the appeal request. The conduct of informal and formal administrative appeals is also regulated by a series of strict time limitations set forth in the Virginia Administrative Code at 12 VAC 30-20-500 et. seq.

Alignment:
To operate with a high degree of customer service, demonstrate responsiveness and competency, and require accountability.

Safeguard and protect the assets of the agency, ensuring that incidents of fraud, waste and abuse are identified and reduced.

Process transactions in a timely and accurate manner in accordance with all HIPAA standards.

This Objective Supports the Following Agency Goals:

- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

This Objective Has The Following Measure(s):

- **Measure 49900.08.01**

  Percentage of all Client and Provider Appeal Decisions issued in full compliance

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: 99.8% for FY 2006

  Measure Target: 100% in FY 2007

  Measure Source and Calculation:
  DMAS Appeals Division database tracks all provider and client appeal deadlines and results. The individual Client and Provider results are averaged to compute the performance values.

Objective 49900.08 Has the Following Strategies:

- Dedicate sufficient administrative support to data entry and monitoring within the appeals electronic case tracking database.

- Continued emphasis upon proactive initial screening of incoming appeal requests to identify recurring issues that might be addressed and resolved without the costs of a lengthy appeal process.
- Replace key personnel, including hearing officers and administrative support, lost to lack of funding and attrition, in order to keep abreast of growing caseloads that must continue to meet the timetables and deadlines set in Medicaid laws, regulations, policy and court orders.